SOS Progress on Feb. 2013 OLA Recommendations

	Recommendation	Findings that prompted the Recommendation	Person Responsible	Estimated Completion Date	Status	Progress Notes
1	The Commissioner of Human Services should eliminate the State-Operated Services Governing Board, relying instead on the commissioner's statutory governance authority and any appropriate delegations of that authority	Past Human Services commissioners created and maintained a Governing Board that included citizen members appointed by the commissioner. This board contributed to a governance structure that muddled accountability and was contrary to state laws.	Anne Barry	May 2013	Completed	DHS has eliminated the SOS Governing Board that included members of the public. In May 2013, the Commissioner delegated the oversight of State Operated Services to a group comprised of the Deputy Commissioner for Direct Care & Treatment, the SOS Chief Medical Director, the DHS Chief Compliance Officer, the SOS Chief Financial Officer, and the Executive Directors of Forensic Treatment Services, Mental Health & Substance Abuse Treatment Services, and Community-Based Services.
2	State-Operated Services should develop performance measures, strategic plans with measurable objectives, and performance-oriented action plans that relate directly to the organization's most fundamental goals.	The Department of Human Services' biennial budgets have provided the Legislature with little concrete information on the performance of State Operated Services (SOS). DHS's public and internal Web sites have provided only limited data for evaluating the performance of SOS. For example, a primary goal of SOS is to improve the mental health of patients at its psychiatric hospitals, yet SOS publishes no measures for this. Measures that indicate the extent to which clients have been screened for physical problems, such as body mass and hypertension, cannot substitute for measures of clients' mental well-being, readmissions to treatment, or satisfaction with services. Two published measures of employee injuries are useful ones to track, but SOS's internal dashboard shows no measures of adverse patient events -- such as patient injuries or deaths, or the extent to which patients have been placed in seclusion or restraint. Also the internal dashboard uses a number of undefined acronyms and provides minimal descriptions of several measures. Finally, SOS's most recent strategic plan -- developed in 2011 -- has a series of broad goals, but it lacks specific performance targets.	Trudy Ohnsorg (lead) Donna Budde	January 2014	Completed	1. New SOS performance measures have been added to DHS's internal and public online dashboards. 2. The DCT Strategic Plan for 2014-18 (encompassing SOS and MSOP) was finalized in March 2014. 3. Accompanying the plan, and in conformance with Results-Based-Accountability principles, are specific key quarterly measures including: a. Rate of Restrictive Interventions b. Rate of Involuntary Return to DCT c. Percent of Clients Awaiting Placement d. OSHA Recordable Incident Rate 4. Additional measures -- including Rate of Progress in Treatment, and Quality of Life of Former Clients now in Community -- are in development. The Quality of Life measure is being developed in partnership with client advocacy organizations. 5. Work is also underway to standardize diagnostic certainty across all SOS programs.

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3	State-Operated Services managers should ensure that the organization's policies and procedures are updated or developed in a timely manner (p. 39).	a. As of mid-2012, about 19% of SOS policies & procedures had not been reviewed within the previous 2 years. b. The SOS Medical Records policy has not been revised since 2001. c. 71% of MSOCS policies & procedures have not been reviewed in at least 2 years. d. As of early 2013, SOS still did not have an updated Incident Reporting Policy posted on iNet. e. There is no SOS-wide policy that addresses methods for transporting clients.	Amanda Kelly	Jan. 31, 2014	In Progress	1. 98% of SOS policies & procedures have been reviewed and/or updated within the past 2 years. 2. The outdated Medcial Records policy has been deleted because individual policies were developed to replace it. 3. An updated SOS Incident Reporting Policy was posted in spring 2013. 4. As of 11/19/14, there was still no SOS-wide policy, or updated set of policies, that addresses methods for transporting clients.
4	The Department of Human Services should evaluate the impact of previous efforts to improve placement options for individuals ready for discharge from the Anoka-Metro Regional Treatment Center and other state-run facilities. It should develop or foster additional placement options as needed.	a. Patients in SOS's acute care hospitals have frequently stayed longer than necessary, resulting in significant fiscal and patient care implications. b. It has taken a long time for DHS to develop comprehensive steps for complying with the 1999 Olmstead ruling, although a plan is now due in mid-2013. c. The Anoka-Metro Regional Treatment Center (AMRTC)has a long waiting list for admission. d. Many patients have long stays at AMRTC. e. Because of its large size, AMRTC qualifies for only limited federal health care funding.	Steve Allen	June 30, 2014	In Progress	1. "Escalation Up" committees are in place for Hennepin County patients at AMRTC and Forensics. New process in place to "escalate up" cases early in treatment when there are "risk factors" for placement challenges. 2. A DHS Transition to Community Work Group has created a process for counties and tribes to access the Legislature's $10.2 million in additional transition funding. 3. DHS is seeking a provider to operate a 16-bed, sub-acute, transitional mental health unit in the Miller North section of the AMRTC campus, beginning in July 2014. Proposal did not receive support from counties. Space vacant. 4. DHS meets monthly with Hennepin County and HCMC to develop strategies for transitioning clients, esp. those at AMRTC. 5. Direct Care & Treatment's Mental Health & Substance Abuse Treatment Services division has hired a Transition Director to oversee efforts to transition clients out of AMRTC and other facilities. 6. DHS is seeking an outside provider to develop a specialty intensive residential treatment (IRTS) facility in the metro area. 7. The 2013 Legislature authorized a Pay for Performance Supportive Housing pilot proposal. Minnesota Management and Budget (MMB), in collaboration with MN Housing Finance Agency (MHFA) and DHS, along with a contracted outside vendor (Corporation for Supportive Housing), are developing a supportive housing model to facilitate transition to community living. The model is projected to save overall state costs for housing and supportive services for a number of persons currently housed in DCT facilities and adult foster care settings. The project is currently in the development stages. Contracts are anticipated to be written in first quarter of 2014. 8. In accordance with Minnesota's Olmstead Plan, DHS's goals for reducing the number of non-acute bed days at AMRTC are as follows: • By December 31, 2014, the percentage of patients at AMRTC who no longer need a hospital level of care will be reduced to 30%. During CY2014, the percentage has fluctuated between 30% and 47%, and was at 39% in September and trending downward, after spiking in July and August. • By December 31, 2015, the percentage will be reduced to 25%. • By December 31, 2016, the percentage will be reduced to 20%. • By December 31, 2017, the percentage will be reduced to 15%. • By December 31, 2018, the percentage will be reduced to 10%.

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	Recommendation	Findings that prompted the Recommendation	Person Responsible	Estimated Completion Date	Status	Progress Notes
5	State-Operated Services should: 1) Establish objectives and strategies for reducing rates of workplace injuries; 2) Amend SOS incident reporting policies to ensure that they are consistent, up-to-date, and sufficiently explanatory; and 3) Clarify in its policies the circumstances in which the Office of Special Investigations should be involved in incident reviews or investigations.	a. Across the SOS system, the estimated annual number of incident reports grew in 2012, with a particularly large increase in reports of physical assaults. b. SOS has had significant workplace safety issues. The federal government computes a workplace safety measure (DART rate) based on Days that employees were Away from work, had Restricted work activity, or were Transferred due to injury or illness. Nationally, the DART rate for psychiatric and substance abuse hospitals in 2011 was 3.9, meaning there were 3.9 recordable cases involving workplace-related injuries or illnesses per 100 full-time employees. In 2011, SOS's program-specific DART rates often exceeded the national average. Rates were 7.8 for MN Security Hospital, 7.2 for AMRTC, 8.1 for MN State-Operated Community Services (MSOCS), and 27.0 for Child & Adolescent Behavioral Health Services (CABHS). Four of the seven SOS community behavioral health hospitals (CBHH) had rates over 8.0. c. SOS implemented overdue improvements to its incident reporting process in 2012, but weaknesses remained in its written policies for incident reporting and investigation.	Susan Thibedeau-Coilan Donna Budde Amanda Kelly	December 2014	In Progress	1. The SOS incident reporting policy was revised in March 2013. In early 2014, new definitions and a new training plan were put in place. 2. Currently working on a set of 4 DCT policies that will clarify the circumstances in which the Office of Special Investigations should be used. These new draft policies will be reviewed by the DCT Policy Sponsors group in December 2014. <u>MNSAFE GOALS FOR FY14:</u> 3. Completed initial MNOSHA voluntary partnership visit at St. Peter CBHH in October 2013, and implemented action plan. MNOSHA will conduct a second partnership visit with DCT's Community Based Services (CBS) beginning Oct. 2, 2014. 4. Seek to reduce average rates of restraint & seclusion by 10% by 06/30/14. As of September 2014, there had been a 19.3% decrease in the number of restrictive intervention procedures compared to the first 3 quarters of FY14. 5. Seek to ensure 100% compliance with all required person-centered, verbal and physical de-escalation training for SOS employees by 06/30/14. Training is continuous, and training aids (EASE Academy, etc.) have been placed online for staff and supervisors to access 24/7. Completion rates range from 31% to 86% among the direct care staff. The plan is to complete training by Dec 2014 through an accelerated training program, with additional trainers assigned. 6. Seek to ensure 100% compliance with required body mechanics training by 06/30/14. Basic body mechanics has been integrated into New Employee Orientation and EASE training. Regional trainers are being identified within CBS, and individual training or re-training is available upon request. 7. Hired occupational health nurse to focus on staff wellness and injury prevention. 8. Patient transport systems have been successfully utilized at several locations including Bemidji and St. Peter. 9. Have implemented a training program for staff on the testing protocols associated with personal alarm systems to ensure functionality and identify maintenance issues. <u>NEW MNSAFE GOALS FOR FY15:</u> 10. Focus on connecting and developing therapeutic relationships with patients. Identify core training requirements for specific programs and develop curriculum. 11. Thoroughly investigate 100% of all OSHA recordable injuries. 12. Develop site-specific violence prevention plans. 13. Update physical job requirements for identified high-risk positions.

SOS Progress on Feb. 2013 OLA Recommendations

	Recommendation	Findings that prompted the Recommendation	Person Responsible	Estimated Completion Date	Status	Progress Notes
6	State-Operated Services should designate a senior administrator to monitor and oversee restraint and seclusion practices throughout the organization.	a. No single policy on the use of restraint and seclusion applies to all SOS facilities, partly because different types of facilities are subject to different state rules and accreditation standards. b. SOS facilities differ in the extent and types of restraint and seclusion they use. c. The failure of SOS management to develop sound policies and practices regarding the use of restraint and seclusion had negative effects on patients and entire facilities. d. Inappropriate use of restraints led to the 2011 closure of MN Extended Treatment Options (METO) and a court settlement for compensating METO's former residents. e. In December 2011, DHS placed the MN Security Hospital on a conditional license for two years and levied a $2,200 fine -- in large part, for problems related to use of restraint and seclusion.	Donna Budde	June 30, 2013	Completed	1. SOS Chief Quality Officer Donna Budde has been assigned to track and monitor use of restraint & seclusion. 2. In August 2013, the Commissioner of Human Services issued a DHS Respect & Dignity Practices Statement that prohibits procedures that cause pain, whether physical, emotional or psychological, and prohibits the use of seclusion and restraints for all programs and services licensed or certified by the department except in situations where there is an immediate threat of harm.

SOS Progress on Feb. 2013 OLA Recommendations

	Recommendation	Findings that prompted the Recommendation	Person Responsible	Estimated Completion Date	Status	Progress Notes
7	State-Operated Services should seek ways to limit overtime use to a reasonable level through administrative actions or negotiations with affected bargaining units.	In recent years, SOS's use of overtime has exceeded the amount targeted by management. SOS aims to limit overtime to 2.5 percent of the total hours worked by direct care staff and to avoid the use of overtime by administrative and support staff. However, actual overtime use has consistently exceeded these targets, and has even grown between fiscal years 2010 and 2013.	Connie Jones	June 2014	Ongoing	1. At Anoka Metro Regional Treatment Center: • In summer 2013, entered into MoU's with AFSCME, MAPE and MNA to change 20 part-time and intermittent FTEs to full-time (voluntarily; no one was required to go full-time). Also added 20 new FTEs (10 HST's and 10 LPN's). Changed the scheduling patterns of vacant positions from a 7/3 rotation to a 6/2, which will provide additional coverage on the weekends. • From July thru Sept 2014, 6.29% of total hours worked at AMRTC were OT hours. 2. At Minnesota Security Hospital: --Implemented a new staffing pattern and schedule in mid-August 2013. --New plan evens out days off for staff, so staffing levels are similar every day. --Overlap shifts to increase communication between shifts. --From July thru Sept 2014, 8.25% of total hours worked in Forensic Services were OT hours. This is up sharply from 4.78% in FY14. The OT hours in 1st Quarter FY15 were driven by two specific requirements of the Conditional License -- ensuring that all Forensics staff complete the Person-Centered Thinking two-day core training and that unscheduled observations be conducted on an ongoing basis on all living units in all Forensic Services programs. OT use was beginning to trend downward again in Nov 2014 because the push to complete training was almost completed. 3. At the 7 CBHHs, from July thru Sept 2014, 3.7% of total hours worked were OT hours. This is down slightly from 3.98% in FY14. 4. At the 6 CARE facilities, from July thru Sept 2014, 4.25% of total hours worked were OT hours. This is down slightly from 4.44% in FY14. 5. At the MSOCS facilities, from July thru Sept 2014, 4.33% of total hours worked were OT hours. This is up slightly from 4.25% in FY14. 6. At the MN Life Bridge program (formerly MSHS-Cambridge), from July thru Sept 2014, 9.63% of total hours worked were OT hours. This is up from 7.11% in FY14.

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	Recommendation	Findings that prompted the Recommendation	Person Responsible	Estimated Completion Date	Status	Progress Notes
8	The Legislature should amend Minnesota Statutes to give district courts continuing jurisdiction over all individuals civilly committed as mentally ill and dangerous or as developmentally disabled, and provide for periodic judicial review of their need for continued commitment.	a. Minnesota laws that provide for indeterminate commitment of certain individuals are unusual and open to legal challenges. b. For individuals committed as Mentally Ill & Dangerous, once a district court makes a final determination and commits the individual for an indeterminate period, its jurisdiction ends. For individuals committed only as Mentally Ill, at least once a year the court must reconsider whether the commitment is appropriate. Although statues provide for a patient-initiated administrative process to review ongoing MI & D commitments, we question whether relying on a patient-initiated process provides sufficient protections. In our view, it would be more legally defensible to have the committing court follow a regular schedule for reviewing whwether a committed individual is still Mentally Ill & Dangerous. Our recommendation also would extend to certain commitments of individuals as Developmentally Disabled, since these commitments are also indeterminate.	Robin Benson	May 2016	In Progress	1. Actions are underway through administrative process at Forensics to review cases to determine who has not been reviewed by the SRB within the last year or so. 2. Consideration is being given to implementing similar process within MSOCS for persons committed as DD. 3. In addition, the Department facilitiated a stakeholder group on MI&D issues that made some recommendations about periodic judicial review in a report submitted to the Legislature in Dec. 2013.
9	The Legislature should amend state law to require the Office of the State Court Administrator to periodically provide the Department of Human Services with information on all individuals committed to the Commissioner of Human Services.	a. For individuals dually committed by the courts to both the Commissioner of Human Services and a non-state facility, state law does not specify exactly what the commissioner's legal responsibilities may be. In fact, the law does not make any provision for "dual commitments." b. Minnesota courts often do not inform DHS when dually committing individuals to both non-state facilities and the Commissioner of Human Services.	Amanda Kelly	Dec. 31, 2013	Completed	In December 2013, the State Court Administrator developed a report for DHS on Civil Commitment Cases Disposed. The report is produced by the Judicial Branch to improve the reliability of court data provided to DHS. As of Dec. 30, 2013, the report is generated weekly and emailed to a DHS email resource account. The report is produced in a Microsoft Excel format which provides DHS the ability to sort and copy the report data to meet their business needs. If DHS needs to acquire additional information on a particular court civil commitment case, DHS has access to MNCIS, the Judicial Branch's electronic records management system. The Cases Disposed report satisfies the minimum statutory requirement for the court to report to the Commissioner of Human Services the names of persons committed to a treatment facility other than a state-operated program or facility. Further, the report provides DHS with a complete list of all civil commitment cases disposed statewide, not just the cases where a patient is committed to a non-state-operated program or facility.

SOS Progress on Feb. 2013 OLA Recommendations

	Recommendation	Findings that prompted the Recommendation	Person Responsible	Estimated Completion Date	Status	Progress Notes
10	The Department of Human Services should periodically test the accuracy of its firearms-related background checks and explore ways to mitigate possible errors (p. 90)	a. State law prohibits individuals who have been committed as mentally ill, developmentally disabled, chemically dependent, or mentally ill and dangerous from possessing a firearm, except in specified circumstances. Local law enformcement authorities are required by law to obtain commitment informatinon from DHS before granting permits to individuals to carry or possess firearms. b. Searches conducted by DHS staff identified 98% of instances in which the individuals should be denied access to firearms based on their commitment history. c. It is unclear why DHS's searches did not reveal certain individuals' prior commitments.	Sondra Johnson	Mar. 31, 2013	Completed	Process has been established to do quarterly random audits of the system for data accuracy. No issues were detected in any of the audits in 2013 or 2014.
11	DHS should publicly clarify what types of disorders are best treated at the Minnesota Security Hospital.	a. By law, any patient found mentally ill and dangerous must be committed to a "secure treatment facility" -- usually this is the Minnesota Security Hospital (MSH). However, it is unclear whether MSH is the most suitable program for some patients committed there. b. About 4% of MSH patients have a primary diagnosis of antisocial personality disorder or some other type of personality disorder. The A.D.A.M. Medical Encyclopedia notes that the most promising treatments of antisocial personality disorder appear to be those that "reward appropriate behavior and have negative consequences for illegal behavior" -- perhaps more like a correctional setting than a medical one. c. The Security Hospital has also consistently served a small number of individuals that are committed as developmentally disabled (DD). Advocates for persons with developmental disabilities have questioned whether the Security Hospital is an appropriate setting for these individuals. d. Security Hospital administrators said that MSH is able to provide differentiated services for DD clients, and that there currently are not better alternative placements.	Steve Pratt	Dec. 31, 2013	Completed	1. SOS and MSH leaders have created a statement saying that MSH: --Provides evaluation and treatment to individuals involved with the legal system due to a crime. --Provides care and treatment to individuals whose mental illness presents as a public safety risk and is assessed as needing a secure facility, and have been committed as MI&D through the court system. --Receives emergency transfers from other State Operated facilities. --Performs competency and criminal responsibility assessment. --Provides inpatient Rule 20 assessments 2. SOS leaders talk about this with stakeholders a couple of times per month.

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	Recommendation	Findings that prompted the Recommendation	Person Responsible	Estimated Completion Date	Status	Progress Notes
12	The Minnesota Security Hospital should adopt policies regarding the hours of counseling, therapy, and other treatment offered per week to help patients address their underlying mental health issues.	a. The Security Hospital is licensed by DHS as a residential facility for adults with mental illness. The rules require the following services to be made available to residents of a program with this license: case management, crisis services, independent living skills training, mental health therapy, motivation services, recreation and leisure time services, socialization services, support groups, social services, and vocational services. The rules do not specify which of these activities constitute "treatment." Furthermore, the rules do not specify how much of these services must be provided. We are not aware of national standards regarding the amount of time per week that a patient in a residential mental health treatment facility should spend in therapy specifically focused on mental health symptoms. b. On average MSH patients had 16 hours of scheduled activities per week. The amount of time devoted to counseling and psychoeducational activities was quite limited. The majority of patients' scheduled hours were consumed by employment, wood shop, recreation, library visits, hobby-related courses, and social activities. Not counting these activities, we found that the average patient had just over one hour per day of scheduled therapeutic activities.	Carol Olson (lead) Steve Pratt	November 2013	Completed	In November 2013, Forensic Treatment Services implemented an action plan that includes the following items: 1. Developed a clear definition of "treatment" for Forensics including defining what services fall under Mental Health Focused Programming and what services fall under Therapeutic Activities. 2. Defined a minimum amount of daily activities offered to Forensics patients. 3. Determined level of expected service delivery by staff and defined this for each discipline.

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	Recommendation	Findings that prompted the Recommendation	Person Responsible	Estimated Completion Date	Status	Progress Notes
13	State-Operated Services should develop clear, consistent standards that address how often Minnesota Security Hospital patients should be seen by a psychiatrist, and it should monitor compliance with these standards.	a. SOS has inconsistent standards that specify how often patients should be seen by psychiatrists, and a majority of patients have been seen less than monthly. b. In 2010, national mental health consultants told SOS they were unaware of comparable programs in the nation with standards that allowed, as did the Security Hospital, for psychiatrist contacts as infrequently as every three months. The consultants said most programs require at least monthly contacts. The Security Hospital's medical director said most of the facility's patients are psychiatrically stable and probably do not need to see a psychiatrist more than once every three months. c. The tracking of psychiatric contacts with patients that started in 2012 was a positive development, although it would be useful for Security Hospital managers to relate this information to whatever standards SOS adopts. It might also be useful to develop reports that relate the frequency of psychiatric contacts to expectation set forth in individualized patient treatment plans.	Steve Pratt	Aug. 1, 2013	Ongoing	At the time of the OLA audit, SOS had a variety of procedures that had conflicting standards. By fall of 2012 they had all been revised to reflect what is in the SOS Medical Staff bylaws: Progress notes will be written weekly for the first month following admission. Progress notes will be written minimally quarterly thereafter, or more often as clinically indicated. On acute units, patients can be seen several times per week if necessary, and there are several people receiving that level of care at any given time. This is audited weekly with an automated report from the electronic health record system.
14	The Department of Human Services should foster or develop new placement options for individuals ready to be discharged from the Minnesota Security Hospital.	a. Some patients have remained at the Minnesota Security Hospital for many years. b. According to Security Hospital administrators, many patients could be discharged from the Security Hospital to less restrictive settings, but there is nowhere to send them. c. The annual number of provisional discharges is very small, but it increased somewhat in 2012. d. To address our recommendation, DHS could consider providing these services itself, by repurposing existing SOS facilities or building new ones. Alternatively, DHS could propose increasing incentives or creating new ones so that non-state providers might be more willing to serve individuals ready to leave the Security Hospital.	Patricia Carlson	Mar. 31, 2014	In Progress	1. Preliminary work includes high-level plan to re-purpose SOS ICF-DD facilities for these clients. (ICF-DD stands for Intermediate Care Facility for persons with Developmental Disabilities.) 2. Four male clients from MSH have moved to an open foster home in Hennepin County. Four female clients from MSH are ready to move to a new foster home in Hennepin County after Jan. 1, 2015.

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	Recommendation	Findings that prompted the Recommendation	Person Responsible	Estimated Completion Date	Status	Progress Notes
15	The Legislature should clarify in state law the role of State-Operated Services' residential and inpatient facilities, stating a mission of serving individuals who cannot be adequately served by other providers.	a. State law does not clearly establish the underlying purpose of DHS's direct provision of services to individuals. b. The vision and mission statements previously adopted by SOS do not clearly differentiate state-operated services from the services of other providers, nor do they indicate the underlying rationale for state-operated services. c. For the most part, county representatives, client advocates, and private service providers we surveyed and interviewed supported a continued state role for DHS in direct service delivery. However, they suggested a need for SOS to offer services that other providers do not -- the "safety net" role referenced earlier. d. In our view, some services now provided directly by DHS could be offered by non-state providers or through stsronger collaboration between state and non-state providers. e. In our view, the department has not always served the most challenging clients, so it seems likely there has been some overlap between the clients served by the department and those served by other providers. f. The MN Security Hospital serves a unique population that has traditionally not been served by private providers, and it should continue this role.	Anne Barry	May 2015	In Progress	Direct Care & Treatment staff have attempted to clarify SOS's mission in the 2014 DCT Strategic Plan.

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	Recommendation	Findings that prompted the Recommendation	Person Responsible	Estimated Completion Date	Status	Progress Notes
16	The Department of Human Services should provide the 2014 Legislature with a substantive plan for the Anoka-Metro Regional Treatment Center.	a. AMRTC faces some significant operating challenges. It has long waiting lists for admission, keeps many patients longer than their symptoms require, and is ineligible for Medicaid payments for many patients. The 2009 Legislature required DHS to prepare a plan on this facility's future, but DHS never provided a detailed proposal. b. More than three-fourths of the county officials responding to our survey said AMRTC serves patients that non-SOS hospitals do not have the resources to serve, and that Anoka's patients are, on average, more challenging to serve than patients in non-state hospitals. c. Funding additional beds at Anoka is an option that should remain under consideration, but pursuing this option must be part of a broader discussion regarding that facility's future. d. DHS's 2014 plan for AMRTC should address whether additional legislative action is necessary to improve placement options. Also, DHS said in 2010 that AMRTC's units should operate in partnership with other Twin Cities hospitals. In the 2014 plan, the department should determine whether this is still a desirable goal -- and, if so, what steps would be needed to accomplish it.	Steve Allen Dave Hartford Sue Koch	Dec 2013	Completed	DHS submitted a plan to the Legislature on Feb. 21, 2014. The Star Tribune published an article about the plan on Mar. 3, 2014.

SOS Progress on Feb. 2013 OLA Recommendations

	Recommendation	Findings that prompted the Recommendation	Person Responsible	Estimated Completion Date	Status	Progress Notes
17	As a pilot program, the Department of Human Services should develop a plan that enables at least one community behavioral health hospital to integrate its services more fully with at least one non-state hospital – through co-location or other collaborative arrangements	a. SOS began opening community behavioral health hospitals (CBHH's) in 2006. b. Because these hospitals are small and not connected with other health care facilities, there have been significant expenditures for on-call services by medical professionals. At times, the CBHH's have been unable to admit patients with a history of violence or aggression, which has frustrated county officials and referring hospitals. c. As of mid-2012, 31 non-state hospitals had behavioral health units. According to data from the MN Hospital Assn., these units have more than 900 beds for patients with mental health needs. d. It is unclear whether the 31 non-state hospitals could meet the demand for inpatient services if the CBHH's no longer existed. e. A collaborative relationship between at least one CBHH and one nearby non-state hospital would allow DHS to explore service efficiencies and better ways to meet patient needs. All the CBHH's are in regions of the state that have at least one non-state hospital with a psychiatric unit. The department tried previously to foster collaboration with non-state hospitals and did not succeed. Making this type of pilot project attractive to a non-state provider might require financial incentives.	Steve Allen	July 1, 2014	In Progress	1. Bemidji CBHH leases its facility from the local hospital provider, Sanford Health, and also contracts with them to provide emergency medical services, laboratory services, building maintenance, and patient meals. 2. Additional planning is occurring in Fergus Falls to develop a community collaborative for health care, including the CBHH, local hospital, county, and other stakeholders. 3. Additional proposals for collaboration to enhance service provision to medically complex and aggressive clients is in development for a possible location in central Minnesota. Development discussions include a private sector provider.

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	Recommendation	Findings that prompted the Recommendation	Person Responsible	Estimated Completion Date	Status	Progress Notes
18	The Department of Human Services should add security arrangements to at least two community behavioral health hospitals that would enable them to admit individuals with the most challenging behaviors.	SOS should serve the clients least able to be served by other providers. These would especially include clients who are aggressive or who have a history of violence. The CBHH's are not equipped to do this effectively right now.	Steve Allen	To Be Determined	In Progress	1. A study was conducted at the St. Peter CBHH in Aug and Sept 2013. The study concluded that DCT leadership and the Legislature should consider re-purposing a living unit at AMRTC to divert challenging patients from the CBHHs. 2. It was subsequently decided, in March 2014, that the re-purposing proposal for the unit at AMRTC would not be pursued because the costs were prohibitive for the counties. DHS will consider whether to seek alternative funding at a later date. 3. The analysis of the St. Peter CBHH led to the conclusion that the CBHH's could not be restructured in a cost-effective manner for the purpose of becoming a referral site for aggressive patients. Expanding services at AMRTC can be done more economically, with stronger staffing options, than can be achieved in the CBHH's. This will require some additional resources, however, which may be included in the agency's 2015 legislative request. 4. The St. Peter CBHH analysis also led to a series of incremental recommendations to enhance all of the CBHHs' capacity for managing aggressive patients, short of becoming sites specifically designed for aggressive patients. Implementation plans are being developed for these recommendations. Some of the recommendations are resource intensive, requiring legislative support. Those requests will be developed in time for the 2015 session. A large-scale effort is underway to begin implementing recommendations from the internal DCT review across all of the CBHH's. The number of assaults has decreased in CY2014 across the CBHH system.

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	Recommendation	Findings that prompted the Recommendation	Person Responsible	Estimated Completion Date	Status	Progress Notes
19	The Department of Human Services should develop a plan for the 2014 Legislature for reducing the number of state-run group homes for individuals with developmental disabilities.	a. The largest single SOS program from a budget perspective is called Minnesota State-Operated Community Services (MSOCS). In FY12, expenditures for this program totaled more than $82 million. For this program, SOS operates 99 facilities licensed as adult foster homes and 15 licensed as intermediate care facilities. The primary diagnosis of about 90% of MSOCS residents is some form of developmental disability (DD), ranging from mild to profound. Most of the remaining residents have a primary diagnosis of a mental illness or traumatic brain injury. Most MSOCS residences provide long-term care rather than treatment. b. Many MSOCS residents could probably be served by non-state facilities. SOS staff agreed that there is potential for significantly reducing the number of state-operated group homes. By their estimates, around half of the current residents of state-run homes for DD clients could be reasonably served by licensed facilities other than those run by DHS. c. The department should present the 2014 Legislature with a plan, based on a detailed analysis of individual facilities and residents. The plan would provide a more precise estimate of the potential for reducing the number of state-run facilities and suggest a timeframe in which this would occur.	Patricia Carlson	Jan. 31, 2014	In Progress	A preliminary draft was prepared in late 2013, and is currently being revised.

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	Recommendation	Findings that prompted the Recommendation	Person Responsible	Estimated Completion Date	Status	Progress Notes
20	The Department of Human Services should discontinue employing staff in the Community Partnership Network whom it does not directly supervise.	a. Several years ago, the Legislature authorized "adult mental health initiatives" around Minnesota in conjunction with plans to close regional treatment centers. In 2008, the state appropriation for these initiatives was moved from SOS to DHS's Adult Mental Health Division. At that time, counties were given the option of hiring the state staff that worked in the initiatives or contracting with SOS to provide staff to continue working in their regions. Many counties chose to contract for staff with SOS. These staff are considered state employees, but they are supervised by counties rather than SOS. This was the beginning of SOS's Community Partnership Network. b. In FY12, the state paid $487,364 in workers' compensation costs for employees in the Community Partnership Network. This was a large increase from previous years. DHS officials expressed concern to us that the state is financially responsible for risks over which it has little control.	Patricia Carlson	July 2015	In Progress	Counties and staff have been notified of the eventual program end of June 30, 2015. The number of employees working within the Community Partnership Network has been reduced to 50, due to retirement and reassignment. More retirements are planned for 2014. Staff continue to look for new employment opportunities within DCT. Communication continues with the counties re: transition plans. The estimated completion date remains the same.